

PHYSICIAN REFERRAL FORM

TO: InSight Vision Center FAX TO: (559) 432-2632 EMAIL TO: referrals@insightvisioncenter.com
 DATE: _____ TIME: _____ AM/PM NUMBER OF PAGES: _____

Physician:

- ☐ Eric J. Poulsen, MD ☐ Azhar I. Salahuddin, MD ☐ W. Andrew Maxwell, MD, PhD
☐ Ashley M. Riley, MD ☐ Sanket S. Shah, MD ☐ Sharon S. Hiyama, OD
☐ Patrick J. Scott, OD ☐ Lisa L. Lu, OD

Requesting Physician Responsibility

Please complete and fax this form for referral appointments. Your patient will be contacted by an InSight Vision Center staff member to schedule the appropriate appointment. The response portion listed below will be filled out and faxed back within 24-48 hours.

URGENT SAME-DAY APPOINTMENTS can be scheduled by calling (559)207-3552 (direct) or (559)449-5050 (main).

Patient Information: (please attach necessary notes, etc.)

Name		Age	
Address			
City	State	Zip	
Main Phone	Alt Phone		
DOB	Male ☐	Female ☐	
Insurance	ID#		

Requesting Physician Information:

Name		
Clinic Name / Specialty		
Address		
City	State	Zip
Phone	Fax	
NPI #		

Requesting physician is responsible for prior authorization.

REFERRAL INFORMATION (to be completed by the requesting physician):

1. Referred for: ☐ Cataract ☐ Diabetes ☐ Glaucoma ☐ Retinal ☐ Refractive Error
- ☐ Free LASIK Consultation ☐ Other: _____

2. Parent or Guardian's name (if patient is under 18): _____

-----PLEASE DO NOT WRITE BELOW THIS LINE-----

TO: _____ FAX TO: (____) _____ NUMBER OF PAGES: _____
 FROM: InSight Vision Center DATE: _____ TIME: _____ AM/PM

Scheduled for Examination: Date: ____ / ____ / ____ Time: _____ AM/PM

Your patient is scheduled to be seen by: ☐ Dr. Poulsen ☐ Dr. Salahuddin ☐ Dr. Maxwell ☐ Dr. Riley ☐ Dr. Shah
☐ Dr. Hiyama ☐ Dr. Scott ☐ Dr. Lu

Main Office Location: ☐
 1360 East Herndon Ave. #201
 Fresno, CA 93720

2nd Location: ☐
 1360 East Herndon Ave. #103
 Fresno, CA 93720

Chestnut Location: ☐
 7015 N. Chestnut Ave, #101
 Fresno, CA 93720